

Patient Perception, Preference and Participation

Patients' perspectives on psychiatric consultations in the Gender Identity Clinic: Implications for patient-centered communication

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ABSTRACT

Objective: To explore transsexual patients' perceptions of communication with psychiatrists in a Gender Identity Clinic and advance understanding of patient centered communication (PCC) in psychiatric, 'gatekeeping' settings.

Methods: 21 qualitative interviews with a convenience sample of clinic patients. Interviews were coded at a semantic level and subject to an inductive thematic analysis.

Results: Patients' perceptions clustered into three themes: (1) aspects of communication that patients described liking; (2) aspects of communication that patients described disliking; and (3) aspects of communication that patients deemed challenging but necessary or useful.

Conclusion: Patients described liking or disliking aspects of communication that reflect existing understandings of PCC. However, a striking feature of their accounts was how they were able to rationalize and reflect pragmatically on their negative communication experiences, welcoming doctors' challenges as an opportunity to consider their life-changing decision to transition from their natal gender.

Practice implications: In certain clinical settings, current operationalizations of PCC may not apply. Patients' perceptions of communication may be enhanced if an analysis of their experiences formed part of the professional training of doctors, who could be invited to consider the functional specificity of communication across settings and the consequences (both immediate and post hoc) of their communication practices.

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1. Introduction

Transsexualism is designated in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV 1994) as a 'Gender Identity Disorder' (GID) [1]. GID is 'characterized by a strong and persistent cross-gender identification and a persistent discomfort with one's sex or sense of inappropriateness in the gender role of that sex' [2]. Transsexualism is thought to affect between 1 in 11,900 and 1 in 45,000 natal males, and between 1 in 30,400 and 1 in 200,000 natal females, though its prevalence may be higher [2,3]. In the UK approximately 95% of patients are referred to the National Health Service (NHS) Gender Identity Clinic (GIC) in London. The world's largest GIC, the facility accepts approximately 500 new adult patients each year [4]. In the majority of cases treatment for GID consists of taking high doses of cross-sex hormones and undergoing sex reassignment surgery (SRS) [5].

Psychiatrists assess patients according to a set of medical criteria, and produce a differential diagnosis [4,5]. Initially patients attend two, hour long consultations with different psychiatrists, following which they attend 30 min follow-up appointments every 3–6 months [4,6]. Before treatment is endorsed patients must commence the Real Life Experience, demonstrating their ability to live full time in their desired gender role. As 'gatekeepers' to treatment, clinic psychiatrists are widely regarded with suspicion by patients [4,6]. Patients have described them as 'unreasonable, erratic and irrational', and reported 'aggressive and rude handling, punitive rules' and 'threats to withdraw treatment' [7]. Likewise GPs have claimed that clinic psychiatrists display 'patronizing attitudes, insensitivity and no sense of caring' and that their patients did not have 'a single positive thing to say about either the process or the consultations' [7].

Psychiatrists account for the 'adversarial' [8] nature of communication at the clinic in terms of the unique challenges that GID poses [4]. Patients often arrive at the GIC having already self-diagnosed and prescribed their own treatment [4]. They are usually reluctant to disclose any ambivalence about their chosen gender identity, believing that it may be a contra-indication for surgery [5,6]. For this reason, psychiatrists argue, 'gender

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identity disorders require collateral history and confirmation' [5].

Despite the challenges that GID poses doctors and patients, there is widespread agreement that psychiatric care in the GIC should be patient centered [9–11]. However, operationalizing a model of patient centered care in the context of the GIC is problematic, because psychiatry is a field of medicine where the agendas of psychiatrists and patients are often in conflict [12]. Consequently 'no specific theory of what constitutes good communication in psychiatry has been developed' [13]. Little is known about which aspects of communication work well for patients in the GIC, which aspects work less well, and why. This study aims to address this gap by providing qualitative evidence of transsexual patients' experiences of, and views about, clinical communication in the GIC. In so doing, it aims to advance understanding of what constitutes patient centered communication (PCC) in psychiatric, gatekeeping settings.

2. Method

2.1. Data collection

The interviewees were selected from a convenience sample of 182 clinic patients who had consented to have their consultations recorded, and later being interviewed, as part of a study of psychiatrist–patient communication in the GIC [14]. Interview requests were sent to 54 of these 182 patients in two phases. 24 responses were received (44%). Of these, 21 patients were successfully interviewed by the first author. Since patients were widely dispersed geographically, 20 semi-structured, audio-recorded interviews were conducted by telephone and one face-to-face. Table 1 gives a brief description of patients. Interviews lasted between 24 and 138 min and were split into five parts (see Table 2). Questions sought to establish the extent of patients' previous contact with the GIC, their expectations and experiences of the referral process, their first appointment, any follow-up appointment/s, and their recommendations regarding the overall assessment and treatment process. Ethical approval was granted by the NHS Central Office of Research Ethics Committees.

2.2. Qualitative analysis

Coding and theme development proceeded in an inductive fashion, without reference to pre-existing hypotheses or theory [15–17]. The second author familiarized herself with the data, first by transcribing verbatim each interview, and then by reading each interview. Upon a second reading all instances (words, phrases) where patients discussed their experiences of, or views about, communication with psychiatrists at the GIC, were coded electronically [16,17]. Codes were identified at the descriptive, semantic level, reflecting patients' own language, meaning, and concepts [16,17]. Reliability was enhanced through an iterative reading of the data, in which both authors discussed and refined codes until they reached agreement [15]. Using the list of all identified codes, those that were similar were clustered to create categories that became sub-themes. Finally, sub-themes that represented patterns were collated to form three themes. Themes thus reflect broader aspects of patients' experiences of communication at the GIC. The quotes presented under each theme illustrate the range of views that appeared recurrently across the interviews. Pseudonyms have been used and identifying details changed in order to preserve doctor and patient anonymity. Ellipses indicate omitted text.

3. Results

Patient views clustered into three themes: (1) aspects of communication that patients described liking; (2) aspects of communication that patients described disliking; and (3) aspects of communication that patients deemed challenging but necessary or useful. These themes were not mutually exclusive for individual patients: every patient identified aspects of communication at the GIC that they liked and disliked and 11 patients reported views relevant to theme three. A model of themes and sub-themes is presented in Fig. 1.

3.1. Aspects of communication that patients described liking

Patients described liking communication styles that were 'friendly' and 'sociable'. Often finding it difficult to specify precisely what identifies such styles, patients routinely framed their discussion of communication practices that worked well by

Table 1
Description of participants.

Pseudonym	Preferred gender	Stage of treatment at time of interview	Number of appointments at GIC prior to interview	Number of doctors consulted at the GIC prior to interview
1. Adele	Male to female	Post SRS	1	1
2. Anthony	Female to male	Referred for breast surgery	4	3
3. Clare	Male to female	Referred for SRS	5	3
4. Kate	Male to female	Referred for SRS	5	3
5. Daisy	Male to female	Under assessment	7	3
6. Natalie ^a	Male to female	Referred for SRS	4	3
7. Louise	Male to female	Post SRS	20 (approx.)	3
8. Tim	Female to male	Under assessment	7	4
9. Ellie	Male to female	Under assessment	5	2
10. Alexandra	Male to female	Referred for SRS	6	2
11. Samantha	Male to female	Referred for SRS	6	2
12. Tamara	Male to female	Post SRS	3	4
13. Victoria	Male to female	Pre SRS	At least 6	3
14. Candice	Male to female	Pre SRS	12	4
15. Gabby	Male to female	Post SRS	9	3
16. Helen	Male to female	Pre SRS	5	2
17. Sarah	Male to female	Pre SRS	8	3
18. Francine	Male to female	Post SRS	6	3
19. Faye	Male to female	Referred for SRS	10	2
20. Stephen	Male to female	Under assessment	5	2
21. Imogen	Male to female	Referred for SRS	7	2

^a Face-to-face interview.

Table 2
Interview guide.

Part one: extent of patient's previous contact with the GIC	
1.	How long have you been attending the Gender Identity Clinic? (Are you still attending?)
2.	How many appointments do you think you have had there so far?
3.	Who have you seen at the clinic? (One clinician or more?)
4.	What's your understanding of the stage of the assessment and treatment process you are at right now?
Part two: patient's expectations, views and experiences of the referral process	
5.	How was it getting referred to the clinic? (Was that a straightforward process? GP good?)
6.	Why did you decide to attend the Gender Identity Clinic initially? (What is your story?)
7.	Before you attended what did you hope the doctors at the clinic might be able to do for you?
8.	Before you attended, what were your expectations of what the overall assessment and treatment process was going to be like? (For example – had you heard anything about the clinic, or the doctors at the clinic? Did you talk to anyone who had already been there? Did they have views and experiences that shaped your expectations of what it was going to be like?)
9.	What were your expectations of what your FIRST appointment was going to be like? (What kinds of things did you think you would talk about with the doctor?)
10.	Did you get any patient information from the clinic in advance of your first appointment about what to expect from the assessment and treatment process and what it was going to be like?
11.	How did you FEEL before your first appointment? (Were you nervous/excited? How were you feeling about seeing the doctor?)
Part three: patient's first appointment	
12.	Could you tell me a bit about your experiences of your very first assessment session? (Did the doctor put you at ease? What kinds of questions did s/he ask you? Did you understand where these questions were going? What was the doctor's style? (Friendly? facilitative? harsh?) Did you have the opportunity to say what you wanted to say during the session? Did you ask any questions? Were your questions answered? Did you feel confident with the doctor that they would make the right decisions on your behalf? Did you trust them?)
13.	How did you FEEL immediately after your first appointment? (Relieved? Angry? Let-down?)
14.	Did your first appointment meet your expectations? (Was it what you expected? Were you surprised by any aspects of it?)
15.	Could you describe any negative, or less positive features of your FIRST assessment session? (In what ways/why was it negative?)
16.	Could you describe any positive features of your first assessment session? (In what ways/why was it positive?)
17.	What, if anything, do you think could be done to improve the first assessment sessions?
Part four: patients' follow up appointment/s	
18.	What did you expect your second appointment to be like?
19.	Did you see the same doctor as at your first appointment or a different doctor?
20.	What was your second appointment actually like? (Did it meet your expectations?)
21.	Can you describe your experiences of the follow-up sessions and the treatment you have received since your first assessment? (Did you have regular appointments? Support through the Real Life Experience?)
22.	Could you describe any negative, or less positive features of the follow-up sessions and the treatment you have received since that first assessment? (In what ways/why was it unhelpful?)
23.	Could you describe any positive features of the follow-up sessions and the treatment you have received since that first assessment? (In what ways/why was it helpful?)
Part five: patients' views on, and recommendations regarding, the overall assessment and treatment process	
24.	Could you summarize your overall experiences of the assessment and treatment process?
25.	What, if anything, could be done to improve the treatment process itself?
26.	Overall, if you were designing the assessment and treatment process, how would you design it? (The real life experience, etc.)
27.	In terms of the doctors at the clinic – overall did you find some doctors more supportive/helpful than others? (What makes a bad clinic doctor? What makes a good clinic doctor? What could be done to improve the doctor's style? Kinds of questions asked?)
28.	Is there anything else we have not covered about your period of assessment or treatment at the clinic that you would like to talk about or add?

comparing the styles of doctors they liked with those they did not like. Patients preferred psychiatrists who were 'approachable', 'easy to talk to', and had a more 'chatty' and 'relaxed' interactional style. These practices allowed them to relax during consultations, and to develop rapport and a less formal relationship with their doctor. Doctor C's style was consistently described in positive terms:

It was just like talking to a friend... He's got a totally different personality, he's – err, a lot more bubbly and got a – genuinely nice attitude... you felt like a somebody rather than just a subject. (Anthony on Dr C)

He was just someone who was far easier to talk to... You could sort of tangent a bit with him and stuff. And sort of... you know... less sort of a psychiatrist–patient sort of... a relationship with him. (Natalie on Dr C)

When psychiatrists showed concern and gave patients the opportunity to talk about all aspects of their lives, not just GID, patients felt they were demonstrating sensitivity, and a genuine interest in them as a 'whole person'. This encouraged them to have confidence in their doctor:

We get on well together you know she always asks after me and she always asks after Liz [the patient's wife] as well when Liz wasn't well that was often her first question... Which I thought again was very sensitive, you know. It was more about the – all of me – rather than just the bit about... that was seeking help for... transgender... and that gave me a lot of confidence in her because I felt she wasn't just looking at one issue she was looking at the person. (Daisy on Dr E)

'Being listened to' and having experiences and feelings respected and validated were also cited as crucial factors in determining whether patients liked their doctor:

Basically when I said something he listened. (Sarah on Dr C)

Finally, patients associated positive communication experiences with psychiatrists who were able and willing to answer any questions they had, and who provided relevant information about the assessment and treatment process:

She showed concern, she did offer, you know, any information that I wanted. (Helen on Dr D)

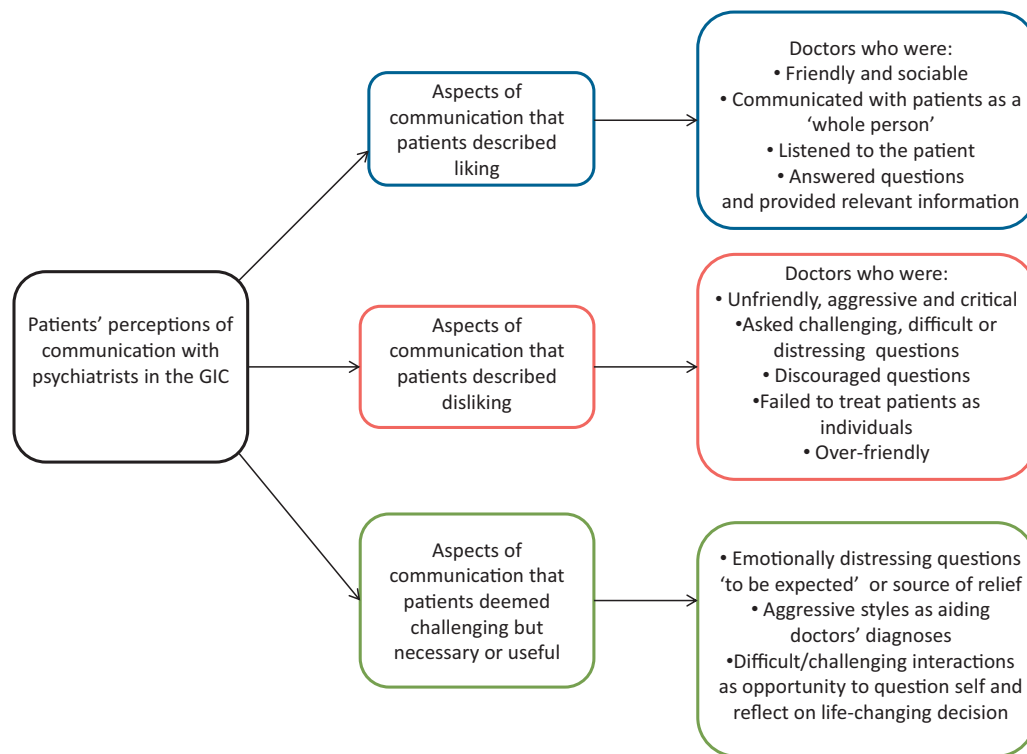


Fig. 1. Themes and sub-themes generated through qualitative analysis of patient interviews.

He was a genius guy... I literally sort of came out the door... bowled over by the amount of information he had thrown at me. He really was a – a – you know, a bountiful fount of information. (Louise on Dr B)

3.2. Aspects of communication that patients described disliking

Patients described disliking the communication styles of doctors they perceived as 'unfriendly'. Often they defined this in terms of what was absent, or missing; for example, the lack of an 'understanding tone' in their voice or a 'welcoming smile'. The communication style of Doctors A, B and E were consistently described in negative terms:

I was a little bit disappointed because Dr E, although she was very professional she again wasn't very welcoming and she wasn't very warm. Not even a smile you know. (Gabby on Dr E)

I didn't actually like him... He didn't have... an understanding tone in his voice, he was just like, 'mm, yes, right'... I was like whoa, sorry!... I just grinned and bared it. (Anthony on Dr A)

Unfriendly interactions were characterized by doctors whose style was described as 'abrupt', 'aggressive' or 'arrogant':

Well I think Dr A is like that, you know, he's a bit, as I say a bit brisk... Well perhaps a bit arrogant... It's what he wanted to do and that was it you know. (Samantha on Dr A)

The moment I walked in the door he attacked me... it was absolutely awful... very dismissive and didn't – no eye contact or anything like that and I came out of there totally confused and very very angry... and very upset. (Gabby on Dr A)

Many patients found these doctors to be insensitive or critical in their handling of certain topics, such as the patient's appearance (e.g., their ability to 'pass' as male or female,

their weight) or behaviors (smoking, excessive drinking or self-medication of cross-sex hormones). This made it difficult for patients to relax during consultations and left them feeling invalidated or offended:

She said ...you ought to be trying harder... why aren't you wearing a wig, you know, or a hat or something... And I felt quite offended by that really. (Gabby on Dr E)

It was tough questioning, if I am honest with you I found Dr B quite aggressive... because I told him... 'I've been self medicating'... he gave me a real dressing down for that. (Francine on Dr B)

Every interviewee recalled having to deal with challenging, difficult or distressing questions during their consultation, requiring them to defend and justify their answers. Patients reported adversarial encounters in which they had to 'jump through hoops' and 'prove' that they have GID:

It was me versus them I had to prove myself, I've always said that this process is rather like the law in reverse you're guilty until proven innocent. (Gabby on all Drs)

I was a bit unsettled, in a way I was thinking you know... is he trying to catch me out and trying to prove that I don't really need it... He was a bit intimidating... It was almost like a – like a grilling. (Samantha on Dr A)

Some patients perceived doctors were rushing them out of the door, withholding information, and discouraging, or failing to answer their questions:

[Int: And did you have the opportunity to ask questions that you wanted to ask as well?] Yeah but it was sort of by implication that he didn't really want me to... because it was bang, bang, bang out the door. (Sarah on Dr B)

She gave me a damn good run for my money... Dr E, ... Tried to squeeze the entire basic two hours into one... At first I thought 'you brute' you know... [Int: Did you ask any questions at all at the end?] No, I just wanted to get out... My first words to my friend Pat when I got out was 'where's the really – nearest pub'. (Alexandra on Dr E)

Some patients felt that psychiatrists were simply 'going through the motions', asking them the same routine questions that every patient was asked, and failing to treat them as an individual:

I saw him the once... it was almost like, 'oh Christ I do this every day of the week, here's another one'... it was very much like that, 'oh here we go again, oh, you're this, you're that, okay'. (Francine on Dr A)

Finally, although patients reported liking the 'friendly' communication style of Dr C, with whom they were able to discuss non-medical subjects, their accounts suggest a fine line where too much 'small talk' by Dr B and 'jokes' about things that had nothing to do with patients' lives or GID, was described as 'over-friendly':

Maybe he was too friendly in a way... He was talking about things that, that really had nothing to do with... why I was there. (Kate on Dr B)

He keeps telling very bad jokes all the time... He kind of tries to put you at your ease. And it is rather over – over friendly perhaps is the word, like he knew me, and I felt a bit put off by that... I sort of expected a professional with a certain level of detachment. (Stephen on Dr B)

3.3. Aspects of communication that patients deemed challenging but necessary or useful

Every interviewee recalled aspects of communication that they liked and disliked. However, a striking feature of 11 patients' accounts was the extent to which they were able to rationalize and reflect pragmatically on their negative communication experiences. This was common in accounts of questions that caused emotional distress, which patients perceived as 'to be expected' or as a source of relief:

The psychiatrist was very supportive, even when the questions she was asking and the depth which she would go into eventually caused me to break down... but I felt that was just part of the process... It upset me but it didn't upset me that she was doing it. I wasn't cross with her or anything because it was obvious that something like that was likely to happen when you're dealing with events of the past. (Daisy on Dr D or E)

It was quite emotional, having to go through all the past again. But it was relieving in a way because... it was like somebody had lifted loads of weight off of my shoulders. (Anthony on Dr A)

Notably, even the most difficult, challenging or aggressive communication experiences were regarded as a necessary and sometimes useful feature of the consultations. Patients rationalized that doctors must adopt such a communicative style because it helps them to make an accurate differential diagnosis. They sometimes even appreciated such experiences:

Mr Edwards was a little aggressive but at the end of the day he needed to be sure about what I was doing, so in a way I mean I kind of expected some aggressive questioning. (Francine on Dr B)

I didn't have any issues with Dr A being aggressive... as I was concerned he had to be sure in his own mind... that it was the

right thing to do for me and not... spend National Health money and also potentially do something to me that would be difficult to reverse... and I was thankful that they were... able to do that for me. (Tamara on Dr A)

Ultimately, many patients welcomed challenging interactions. For some, these communications reinforced the seriousness of the process they were embarking on and helped them to 'question themselves':

I thought to myself 'what the hell is going to happen next sort of thing, if that's the first one God help me when I get to the second one'... it did er illustrate that this isn't a game... Which I knew anyway but it sort of put that firmly in its place you know... And that I think is a good thing because... it erm should strengthen your resolve. (Alexandra on Dr E)

I suppose it does you good as well to have a bad appointment... I think it makes you come down to earth a little bit... you get a bad one that basically... makes you think 'jeez should I, you know, did I do something wrong there or should I have done that a different way'... I suppose it helps you question yourself again. (Tim on Drs A and B)

Others welcomed these experiences as an opportunity to reflect more deeply upon the permanent, life-changing decision to transition from their natal gender, and its possible impact on their lives:

I found Dr B very direct and actually I appreciated that because he challenged me directly with... 'why do you think you are a transsexual?... And I can understand why... people might get upset by it, but for me that was exactly the sort of question that I wanted... because I wanted to try and explain it myself... that was part of the process that I needed to go through to try and establish in my own mind exactly where I was. So I actually appreciated his approach... I suppose I had gone there expecting real aggression. (Daisy on Dr B)

At the time it was awful and my wife still hates thinking about it but... in retrospect... I can understand how he was conducting it... He said to her bluntly, 'can you cope with living with him like this every day for the rest of your life? Can you imagine yourself sitting on Blackpool seafront age 70 with your blue rinses doing your knitting?'... We can laugh about it now but... I think he knew that he'd hit a nerve, and I still think that is what he wanted to do... In retrospect that probably did help, we did have to move forward... to address that point. (Ellie on Dr B)

4. Discussion and conclusion

4.1. Discussion

This study sought to provide qualitative evidence of patients' experiences of, and views about communication with psychiatrists in the GIC, in order to advance understanding of what constitutes PCC in psychiatric, gatekeeping settings. Patients described liking the communication style of doctors who were friendly and sociable, communicated with them as a whole person, listened to them, answered their questions and provided relevant information. While there is no current agreed upon consensus regarding the communication practices that constitute PCC [18–20], these features correlate broadly with operationalizations of PCC in the literature: PCC promotes a relationship between doctor and patient in which patients collaborate as partners in healthcare decision-making, and where there is mutuality, power sharing and an empathic, biopsychosocial orientation to the patient as a whole

person [18,21,22]. In contrast, patients described disliking the communication styles of doctors they perceived as unfriendly, aggressive and critical, who asked questions that were challenging, difficult or distressing, who discouraged questions, failed to treat them as an individual, and were over-friendly. These communication features are highlighted by transgender community patient surveys [7] and correlate broadly with what has been termed 'paternalistic', 'authoritarian', and 'asymmetrical' communication that run counter to PCC [23,24], suggesting that the basic goals of patient centered care enshrined in best practice documents are not being met in practice.

Although certain doctor's communication styles were consistently described in negative terms, a notable feature of our data is that paradoxically, patients also drew positives from interactions with psychiatrists who adopted these communication styles. Indeed, a striking feature of patients' accounts is the extent to which they were able to rationalize and reflect pragmatically on unpleasant communication experiences. Patients perceived emotionally distressing questions as 'to be expected' or a source of relief, and direct or aggressive styles as aiding doctors' diagnoses. Ultimately many patients welcomed challenging interactions with doctors as an opportunity to question themselves and reflect on their life-changing decision to transition from their natal gender.

4.1.1. Limitations

Our methods were limited in three main ways: first, selecting interviewees from a convenience sample of 182 patients who had consented to the recording of their consultations was not an optimal strategy for accessing the full range of perspectives held by the target population. The logistics of data collection at the clinic, ethical requirements and funding prevented us from adopting a purposive sampling strategy with selection of participants based on salient features of the patient population and continuing recruitment, modifying the interview schedule, and conducting analyses in parallel with data collection until theoretical saturation was reached. Such a strategy would have ensured important data were not missing and maximized the validity of the results. Second, it is quite possible that the 24 patients who responded to interview request letters were more polarized in their views than those who did not respond, who may have been comparatively neutral about their experiences at the clinic. Finally, telephone interviews prevent access to non-verbal channels of communication and may have resulted in less rich data than could have been obtained in person or through virtual, video-based methods.

4.2. Conclusion

Our findings contribute to the growing debate over the achievability and desirability of PCC by suggesting that what constitutes patient centeredness in psychiatric, gatekeeping settings, is by no means straightforward [25]. That patients often drew positives from communication styles that are at odds with current understandings of PCC suggests that a patient centered style, as conventionally defined, may not be suited to all settings, patients, and conditions [22,24]. Psychiatric diagnoses rely primarily on patients' reports of feelings, symptoms and behaviors, and clinicians' provocative or challenging questioning style is often driven by a concern to validate potentially distorted information [26,27]. Therefore, identifying communication styles that work well for, and meet the respective needs of, both clinician and patient, may be an impossible task. Despite this, that patients in our study were able to rationalize and reflect pragmatically on their negative communication experiences suggests that styles of questioning that patients deem challenging are not intrinsically bad or antithetical to PCC. This does not mean that patients must value their communication experiences, albeit in retrospect, for

communication to be regarded as 'good'. 'Good', 'skilled' or 'patient centered' communication does not necessarily equal 'comfortable' communication where clinician and patient are perfectly aligned. Whether or not a patient ultimately welcomes such practices, challenging aspects of patients' responses that are not fully explained, may be a valuable clinical skill that helps doctors gauge patients' commitment to their transition, increasing the validity of their diagnoses [25,27].

For Pilnick and Dingwall, the pervasiveness of asymmetry in clinician–patient communication 'should raise questions... about the continued upholding of patient centered medicine as a panacea' [23,28]. This does not mean that PCC is not desirable or achievable, that 'anything goes' or that we should endorse a wholesale return to a paternalistic, biomedical form of medicine. Rather, what is crucial when evaluating practices of communication in different medical domains, is to consider, in light of the functional purpose of the communication in that setting, whether patients' relatively positive, post hoc views of their experiences of communication in such settings, warrant the potentially short term, real time distress that 'aggressive' or 'hostile' questioning practices may engender [25]. Future research is needed to develop operationalizations of PCC that are sensitive to the contextual variability and functional specificity of communication across the full range of medical domains.

4.3. Practice implications

Our data are preliminary and implications are contingent on further work. However, findings are suggestive of clinical settings where current operationalizations of PCC may not apply, and may need to be adapted to suit the demands of the particular clinical situation. Patients' perceptions of communication may be enhanced if an analysis of transcripts of their experiences of communication in different medical domains formed part of the professional training of doctors. Doctors could be invited to work together to consider how the functional specificity of communication across settings can impact patients' experiences, and reflect critically on the potential consequences (both immediate and post hoc) of their communication practices.

Contributions

The first author conducted the interviews and drafted the final version of the paper. The second author transcribed the interviews, coded the data, refined themes under the supervision of the first author, and produced the first draft of the paper.

Conflict of interest

None to declare.

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References

- [1] American Psychiatric Association. Diagnostic and statistical manual of mental disorders: fourth edition – text revision (DSM-IV-TR). Washington, DC: American Psychiatric Association; 2000.
- [2] World Professional Association for Transgender Health. Standards of care for gender identity disorders, seventh version: <http://www.wpath.org/documents/Standards%20of%20Care%20V7%20-%202011%20WPATH.pdf>.

- [3] Reed B, Rhodes S, Schofield P, Wylie K. Gender variance in the UK: prevalence, incidence growth and geographical distribution; <http://gires.org.uk/assets/Medpro-Assets/GenderVarianceUK-report.pdf>.
- [4] Green R. Potholes in the interview road with gender dysphoric patients: contentious areas in clinical practice. *Sexologies* 2008;17:245–57.
- [5] Barrett J. Transsexual and other disorders of gender identity: a practical guide to management. Oxon: Radcliffe Publishing; 2007.
- [6] Speer SA, Parsons C. Gatekeeping gender: some features of the use of hypothetical questions in the psychiatric assessment of transsexual patients. *Discourse Soc* 2006;17:785–812.
- [7] Burns C. Collected essays in trans healthcare politics: documenting the scandal of how medicine lost the trust of trans people; http://ai.eecs.umich.edu/people/conway/TS/Health/Essays_In_Trans_Healthcare.pdf.
- [8] Newman LK. Transgender issues. In: Ussher J, editor. *Women's health: contemporary international perspectives*. Leicester: BPS Books; 2000 p. 394–404.
- [9] Combs R, Turner L, Whittle S. Gender identity services in England: the mapping project report prepared for the Department of Health; http://www.pfc.org.uk/pdf/UK_GIC_%20Mapping&ServicesProject%204DoH.pdf.
- [10] Department of Health. Trans: a practical guide for the NHS; <http://www.parliament.uk/deposits/depositedpapers/2012/DEP2012-0096.pdf>.
- [11] Royal College of Psychiatrists Intercollegiate SOC Committee. Good practice guidelines for the assessment and treatment of gender dysphoria; <http://www.rcpsych.ac.uk/pdf/Standards%20of%20Care%20Draft%20v8%203b%20final.pdf>.
- [12] Quirk A, Chaplin R, Lelliott P, Seale C. How pressure is applied in shared decisions about antipsychotic medication: a conversation analytic study of psychiatric outpatient consultations. *Social Health Illn* 2012;34:95–113.
- [13] Priebe S, Dimic S, Wildgrube C, Jankovic J, Cushing A, McCabe R. Good communication in psychiatry – a conceptual review. *Eur Psychol* 2011;26:403–7.
- [14] Speer S, Green R. Transsexual identities: constructions of gender in an NHS Gender Identity Clinic: full research report ESRC end of award report, RES-148-25-0029. Swindon: ESRC; 2008.
- [15] Boyatzis RE. Transforming qualitative information: thematic analysis and code development. London: Sage; 1998.
- [16] Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006;3:77–101.
- [17] Braun V, Clarke V. Thematic analysis. In: Cooper H, editor. *APA handbook of research methods in psychology*, vol. 2. Washington, DC: American Psychological Association; 2012.
- [18] Saha S, Beach MC. The impact of patient-centred communication on patients' decision making and evaluations of physicians: a randomized study using video vignettes. *Patient Educ Couns* 2011;84:386–92.
- [19] Epstein RM, Franks P, Fiscella K, Shields G, Meldrum SC, Kravitz RL, et al. Measuring patient-centered communication in patient–physician consultations: theoretical and practical issues. *Soc Sci Med* 2005;61:1516–28.
- [20] Mead N, Bower P. Patient-centred consultations and outcomes in primary care: a review of the literature. *Patient Educ Couns* 2002;48:51–61.
- [21] Clayton MF, Latimer S, Dunn TW, Haas L. Assessing patient-centred communication in a family practice setting: how do we measure it, and whose opinion matters? *Patient Educ Couns* 2011;84:294–302.
- [22] Zandbelt LC, Smets EMA, Oort FJ, de Haes HC. Coding patient-centred behaviour in the medical encounter. *Soc Sci Med* 2005;61:661–71.
- [23] Pilnick A, Dingwall R. On the remarkable persistence of asymmetry in doctor/patient interaction: a critical review. *Soc Sci Med* 2011;72:1374–82.
- [24] Swenson SL, Zettler P, Lo B. 'She gave it her best shot right away': patient experiences of biomedical and patient-centred communication. *Patient Educ Couns* 2006;61:200–11.
- [25] Speer SA. Talking about sex with patients in the Gender Identity Clinic: Implications for training and practice. *Health*. in press.
- [26] Shea SC. *Psychiatric interviewing: the art of understanding: a practical guide for psychiatrists, counsellors, social workers, nurses, and other mental health professionals*, 2d ed., Philadelphia: Saunders; 1998.
- [27] Speer SA. Pursuing views and testing commitments: hypothetical questions in the psychiatric assessments of transsexual patients. In: Freed A, Ehrich S, editors. *Why do you ask? The function of questions in institutional discourse*. New York: Oxford University Press; 2010. p. 133–58.
- [28] Salmon P, Young B. Core assumptions and research opportunities in clinical communication. *Patient Educ Couns* 2005;58:225–34.